



# STATE OF INDIANA

ERIC J. HOLCOMB, GOVERNOR

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**Indiana Department of Insurance**

Stephen W. Robertson, Commissioner  
311 W. Washington Street, Suite 103  
Indianapolis, Indiana 46204-2787  
Telephone: 317-232-2385  
Fax: 317-232-5251  
Website: [in.gov/doi](http://in.gov/doi)

Re: Problem Report Number:  
Complainant:

Dear

It appears you are filing this complaint on behalf of someone else, you are not the insured or policy owner of the insurance policy or annuity referenced in this complaint. If your inquiry is not for yourself as the third party claimant, please ask the party involved to sign the enclosed Authorization to Release Information ("Authorization"). I will not be able to discuss the facts of the case with you until the signed Authorization is provided.

In addition to the Authorization, please provide any documentation you may not have submitted with the initial complaint. Copies of letters, receipts or policy forms could prove to be very beneficial in the investigation.

If you have any questions or concerns regarding this matter, you may contact 1-800-622-4461 or 317-232-2395

Sincerely,

Enclosure

ACCREDITED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

AGENCY SERVICES 317-232-2413	COMPANY COMPLIANCE 317-232-3495	CONSUMER SERVICES 317-232-2395/1-800-622-4461	FINANCIAL SERVICES 317-232-2390	MEDICAL MALPRACTICE 317-232-2402	COMPANY RECORDS 317-232-5692	STATE HEALTH INSURANCE PROGRAM 1-800-452-4800
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## **Authorization to Release Information**

**I hereby authorize representatives/employees of the Indiana Department of Insurance (“Department”)** to discuss my complaint and my insurance policies and/or annuity contracts with \_\_\_\_\_.  
Name of your chosen representative in this matter

I am aware the information disclosed may include, but is not limited to, policy terms, policy values and named insureds or beneficiaries. Other information disclosed may also include health information and financial information. I understand any changes made to the policies or contracts will require prior authorization by me. I wish to restrict the authorization to release information to the policies or contracts listed below:

Policy/Contract #: \_\_\_\_\_ Company Name: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_ Company Name: \_\_\_\_\_

Dated: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Return the completed form to:

Indiana Department of Insurance  
311 W. Washington Street, Ste. 300  
Indianapolis, IN 46204